Memorandum

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

DATE:04/01/19

TIME: 1100 Hours

CASE #: 2019-775

RE: In-Person Interview, Eric Hernandez (DOC)

FROM: Jim Noss, Investigator

On the above date and time Supervisor Burkholder and I met with Hernandez at our offices. Hernandez is one of the Regional Managers for the health programs related to DOC. His duties include investigating complaints related to the clinics at the DOC facilities. In this case, Monroe Correctional Center where the Respondent was assigned as the Medical Director. Hernandez does not have a medical background, but a business management background and has been in his position about seven years. The purpose of the meeting was to review new materials and establish what additional records were available related to this incident.

According to Hernandez, he first became involved in this issue when he was notified by a Gabriel Gaspar and Dr. Sara Kariko about complaints from senior medical staff concerning the Respondent. Apparently, the staff had been complaining about quality of care issues involving the Respondent. Initial reviews of several cases were completed by Dr. Gaspar who then contacted Dr. Kariko as she believed the care was sub-standard. At that point Hernandez became involved which ultimately lead to a full review of the Respondents treatment/supervision of patients at the facility.

Hernandez explained the records for any patients in question were reviewed by several other doctors who also found the care to be substandard. There also appeared to be a lack of supervision related to the action of senior medical staff (PA's), in certain instances. After these issues were reviewed the Respondent was placed on administrative sometime in November of 2018. All in-house medical records were obtained and reviewed. Initially, there were six cases the reviewing doctors felt were substandard care, three of these possibly contributing to the death of the patient. Additional patient reviews were conducted and these identified four additional case, also possible contributing to the death of the patients.

Case summaries were reviewed with Hernandez confirming what documents had been provided. These were completed by Dr. David with a summary of the medical history for each patient.

Medical records for the patients had been provided, but additional records for the four additional patient were still at DOC. Hernandez agreed to provide these records upon request as they are a part of their case file.

According to Hernandez the Respondent has no prior history of disciplinary issue with her job. This is the first time that an issue has arisen. Since their investigation was initiated there has been one inquiry from her previous employer Corizon, a private jail services provider. This is a business located in Arizona and it is believed that there has been some type of litigation pursued against Corizon. Thus, they are trying to contact the Respondent. No other specifics were known concerning this issue.

When asked about interviewing staff the only individuals who had not been interviewed were some of the medical staff such as the PA's. I asked if the staff would have any issues with being interviewed. Hernandez said they would probably cooperate without hesitation. When asked about how the Respondent got along with staff, Hernandez pointed out that she was not liked. Apparently, when the Respondent was originally hired, she attempted to implement more accountability as it related to the clinic. The prior Medical Director had taken a more hands off approach as it related to the clinic, giving staff more flexibility. The intent appeared to be treat the medical delivery as more of a managed care model. This new approach lead to a vote of no confidence on the part of a union that represented middle management.

Hernandez made clear that while this series of events took place at about the same time they were treated as mutually exclusive as far as the internal investigation. The quality of care issues were significant and it ultimately was the Respondents responsibility to make certain that things operated in the interest of the patients.

When asked about the status of the Respondent as it related to current employment, I was told that a pre-disciplinary meeting had just taken place this AM. Hernandez explained that during his discussions with her, the Respondent seemed to be taking it all in stride, as if there was no issue. When the Respondent was discussing the matter she seemed to believe there were no standard of care issues. Essentially, she believed her care of the patients and the care given fell within acceptable standards of care. In addition it appeared as though the Respondent was claiming to have been involved in the care of the patient frequently. This appeared to be contrary to the information uncovered in the internal investigation. Hernandez said that he would be completing his notes shortly on this part of the investigation.

Hernandez was asked about policies or procedures related to patients being housed or admitted. I was told that he would be able to provide several policies. A quality review was asked about and it was described as CQUIP. This involves reviewing patient cases and internal processes. The schedule was quarterly and annually for the more in-depth reviews. Hernandez did not believe that the Respondent participated in more than one review, but he was unsure what it was about.

Hernandez did not believe that the Respondent was currently working anywhere else at this time. He did state that it was unclear if the Respondent appreciated the seriousness of this issue. Although, the attorney for the Respondent seemed to appreciate the nature of it.

END